No. 86-1419

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IN THE
SUPREME COURT OF THE UNITED STATES

October Term 1987

STATE OF OREGON
DEPARTMENT OF HUMAN RESOURCES;
RICHARD C. LADD,

Petitioners,

vs.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

On Writ of Certiorari to the
United States Court of Appeals
for the Ninth Circuit

Brief of the States of Arizona (through the Arizona Health Care Cost Containment System), Arkansas, California, Colorado, Connecticut, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming, and the Northern Mariana Islands as Amici Curiae in Support of Petitioners

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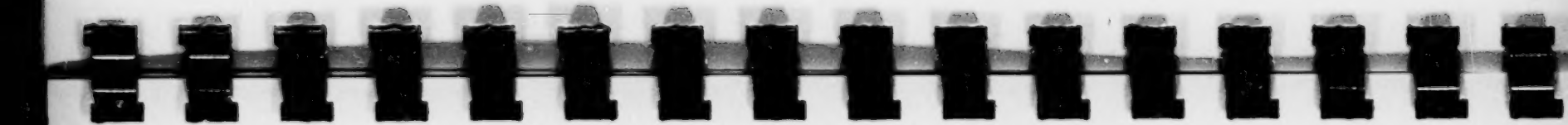


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Pursuant to Rule 36.4 of the Rules of this Court, the States of Arkansas, Arizona (through the Arizona Health Care Cost Containment System), California, Colorado, Connecticut, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Dakota, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming, and the Northern Mariana Islands respectfully submit this brief as amici curiae. The amici support the effort of the petitioner State of Oregon Department of Human Resources ("Oregon") to obtain reversal of the decision of the Court of Appeals for the Ninth Circuit (803 F.2d 1060 (1986)). The Court of Appeals reversed the order of dismissal entered by

the District Court and remanded this matter for trial, holding that respondents had stated a claim cognizable under 42 U.S.C. § 1983.

STATEMENT OF INTEREST

Each of the amici participates (or expects to participate[1/]) in the Medicaid program established by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396s. Pursuant to that program, the amici provide medical assistance to eligible needy citizens who are unable to provide for their medical care from their own resources.

As required by federal law, the Medicaid programs of each of the amici

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1/ The Northern Mariana Islands has applied to participate in the Medicaid program. Although The Northern Mariana Islands is not a State but a U.S. Territory, we use the term "State" in this brief to include it as well.

States encompass institutional medical care, including care in inpatient hospitals, skilled nursing facilities, and intermediate care facilities (hereinafter referred to as institutional "providers").2/ Medical care provided in these institutional settings comprises a major element of the Medicaid programs of the amici states, as is the case in most states throughout the nation.

Annually, if not more frequently, the amici establish Medicaid reimbursement rates for thousands of institutional

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2/ Skilled nursing facilities provide services to individuals who need, on a daily basis, care provided or supervised by skilled nursing personnel. 42 U.S.C. § 1396d(f). Intermediate care facilities provide services to individuals who do not require the degree of care and treatment provided by a skilled nursing facility, but who, because of their mental or physical condition, require institutional care and services, above the level of room and board. Id. § 1396d(c).

providers, and, as mandated by federal law, each amicus state has established administrative appeal procedures whereby each institutional provider may obtain review of its reimbursement rate.3/ Each amicus has a vital interest in the outcome of this case. The core question

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3/ These administrative appeal procedures are set forth, for example, at Alaska Stat. § 47.07.075 (1984); Cal. Welf. & Inst. Code § 14087.27 (1987); Haw. Admin. R. § 17-748 (1985); Idaho Code §§ 56-132 (1986); Kan. Stat. Ann. § 75-3306 (1984); Me. Med. Assis. Manual § 1.18 (1979); Miss. Code Ann. § 43-13-121(i)(a)(iv) (Supp. 1985); Mo. Rev. Stat. §§ 208.156, 621.055 (1983); Nev. Medicaid Services Manual § 506 (1987); N.J. Court Rules § 2:2-3(2) (1987); N.C. Admin. Proc. Act, arts. 3 & 4, ch. 150B (1986); N.D. Admin. Code § 75-02-06-16(7) (1986); Ohio Rev. Code Ann. § 5111.06 (1981); Utah Code Ann. § 26-23-2 (1984); Va. Code § 9-6.14:1 (1985); Vt. Stat. Ann. tit. 33, § 195 (1978); Wash. Rev. Code § 74.46.770 (1987); and Wis. Stat. § 227.42 (1985-86).

in this case is whether, as the Court of Appeals held, a complaint about the adequacy of the Medicaid reimbursement rate that a state has established for a particular institutional provider entitles the provider to sue the state in federal court under 42 U.S.C. § 1983.4/ Each amicus is interested in the resolution of this issue because, like Oregon, each would potentially be subject to thousands

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4/ 42 U.S.C. § 1983 (1982) provides in pertinent part:

> "Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . .."

of suits each year in federal court if the broad holding of the Court of Appeals is sustained. This substantial interest warrants the submission of this brief in support of Oregon's effort to obtain reversal of the Court of Appeals' decision below.

LEGAL AND PROCEDURAL BACKGROUND

Respondents' complaint alleged as a cause of action that Oregon had violated the requirements of 42 U.S.C. § 1396a(a)(13)(A).[5/] See Appendix E to Petitioners'

5/ Section 1396a(a)(13)(A) requires each state participating in the Medicaid program to provide in its State Plan for the reimbursement of providers of institutional care

> "through the use of rates (determined in accordance with methods and standards developed by the States and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low

(Footnote Continued)

Petition for Certiorari (P. Pet. Cert. App. E), ¶¶ 15, 31.

While respondents' complaint recites a number of factual allegations, the Court of Appeals cited, and its holding was premised upon, only one: that, in establishing the reimbursement rate

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(Footnote Continued)

> income patients with special needs . . .) which the State finds, and makes assurances satisfactory to the Secretary [of Health and Human Services], are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with the applicable State and Federal laws, regulations and quality and safety standards . . .."

Respondents also claimed that Oregon's conduct constituted a breach of contract, a deprivation of constitutional rights, and a violation of state law and federal Medicaid regulations. P. Pet. Cert. App. E, ¶¶ 31, 34, 37. The Court below did not reach the issue of whether section 1983 afforded respondents a remedy for those alleged violations.

for respondent Coos Bay Care Center, Oregon "withheld certain 'heavy care' Medicaid payments and reimbursements."[6/] 803 F.2d at 1061. For Oregon's alleged violation of section 1396a (a)(13)(A) in failing to reimburse respondent Coos Bay's heavy-care costs, respondents sought a remedy under 42 U.S.C. § 1983.

6/ Respondents alleged that applicable state regulations provided for complete reimbursement for the costs of providing heavy care. P. Pet. Cert. App. E ¶ 17. Respondents' complaint also alleged that Oregon had developed a policy of refusing to pay the costs of heavy care to respondent Coos Bay Care Center as well as to other long-term health care facilities providing care to heavy-care patients. Id., ¶¶ 23, 24. In addition, respondents' affiant alleged that Oregon had failed to make available to respondent Coos Bay Center an administrative procedure whereby it could obtain review of its rate. Respondents' Brief in Opposition to Certiorari, p. 19. The Court of Appeals did not premise its holding on the existence of these allegations and, in fact, did not even acknowledge these allegations.

The District Court, adopting a magistrate's findings and recommendations, dismissed respondents' action for failure to state a claim and lack of jurisdiction. P. Pet. Cert. App. B. The magistrate, relying on this Court's decision in Pennhurst State School and Hospital v. Halderman, 451 U.S. 1 (1981), had concluded, inter alia, that the Medicaid statute and regulations create no substantive, enforceable rights or private right of action. P. Pet. Cert. App. C, pp. 12-13.

The Court of Appeals reversed the decision of the District Court and remanded the action for trial. The Court of Appeals found that this Court's decision in Maine v. Thiboutot, 448 U.S. 1 (1980) (section 1983 affords a remedy for violation of provisions of the Social Security Act), obviated the need for

lengthy analysis and required a finding that respondents' complaint alleging violations of section 1396a(a)(13)(A) was entitled to consideration on the merits under section 1983. 803 F.2d at 1062. Further, while acknowledging that the Medicaid statute "permits" states to establish "complementary" administrative review procedures for disputes over Medicaid reimbursement, the Court of Appeals found no indication in the statute of a congressional intent to foreclose enforcement of the statute's provisions under section 1983. Id. The court also found no bar to an action by Medicaid patients and their health care providers to enforce section 1396a(a)(13)(A). Id. The court held that "statutory rights under Title XIX of the Social Security Act [had] been alleged in the complaint

which are sufficient to state a claim under 42 U.S.C. § 1983." Id. at 1063.

SUMMARY OF ARGUMENT

Amici respectfully submit that the Court of Appeals' broad holding -- that an institutional Medicaid provider and its patients may bring suit under section 1983 to challenge the adequacy of the provider's particular Medicaid reimbursement rate[7/] -- must be reversed.

7/ The Court of Appeals' decision necessarily is premised on the holding that section 1983 affords a federal forum to challenge a particular provider rate because the court gave no indication that its decision was dependent on the existence in respondents' complaint of the allegation that Oregon had a general policy of refusal to reimburse heavy-care costs, or on the allegation that Oregon had effectively denied heavy-care providers the opportunity to have meaningful administrative review of their rates. Indeed, as earlier noted, the court made no reference to such allegations. Amici believe that the Court need not decide

(Footnote Continued)

The effect of the court's decision is improperly to permit any institutional provider to sue under section 1983 to challenge its Medicaid reimbursement rate, even though the Medicaid statute imposes no requirement that a state make assurances about the rate established for each individual provider. The decision below should also be reversed because, in permitting a provider to challenge its reimbursement rate in federal court without regard to whether the provider has sought state administrative review of the rate, the decision frustrates the congressional intent that the

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(Footnote Continued)
here whether such allegations state a claim cognizable under section 1983. As amici explain below, to the extent that the holding below permits a section 1983 suit to be maintained to challenge a particular provider rate, it is overly broad and should not be permitted to stand.

states have broad latitude to implement their Medicaid reimbursement plans.

The Court of Appeals' holding that a provider may sue under section 1983 to challenge its reimbursement rate is also erroneous because federal law, which mandates that the states provide administrative appeal procedures whereby institutional Medicaid providers may obtain review of their rates, establishes a comprehensive remedial scheme that should preclude a remedy under section 1983.[8/] The effects of leaving the

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8/ Amici do not discuss in detail this point (which follows from this Court's decision in Middlesex County Sewerage Authority v. National Sea Clammers Ass'n, 453 U.S. 1, 19-21 (1980)) so as not to burden the Court with repetition of an argument ably presented by the petitioner in its brief. For the same reason amici do not repeat, but fully endorse, the argument, presented in Oregon's brief in support of its

(Footnote Continued)

holding below to stand will be to disrupt, if not to thwart completely, the states' carefully-tailored rate review procedures and to impose a severe burden on state resources and federal court dockets.

ARGUMENT

THE COURT OF APPEALS' HOLDING THAT SECTION 1983 AFFORDS AN INSTITUTIONAL MEDICAID PROVIDER A REMEDY TO CHALLENGE ITS PARTICULAR REIMBURSEMENT RATE IS ERRONEOUS, FRUSTRATES THE OBJECTIVES UNDERLYING SECTION 1396a(a)(13)(A), AND DISRUPTS THE REMEDIAL SCHEME MANDATED BY CONGRESS.

(Footnote Continued)
petition for certiorari, that a violation of state Medicaid regulations does not amount to a violation of federal statutory rights that is cognizable under section 1983. As Oregon argues, and as supported by the reasoning of the court in Oberlander v. Perales, 740 F.2d 116 (2d. Cir. 1984), section 1983 should not be deemed to provide a federal forum for respondents' complaint that Oregon failed to provide an element of reimbursement to which respondent Coos Bay claims entitlement under state administrative regulations.

A. The Holding Below Rests on the Erroneous Assumption that Section 1396a(a)(13)(A) Imposes Requirements with Respect to the Particular Rates Established for Individual Medicaid Providers.

Section 1983 provides a remedy that "encompasses violations of federal statutory . . . law." Maine v. Thiboutot, 448 U.S. 1, 4 (1980). The corollary of that rule, as this Court has recognized, is that a section 1983 remedy is not available where no violation of the terms of a federal statute is alleged, and where the relevant statute imposes on a state no obligation to do what it has allegedly failed to do. See Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 28-29 (1980). The fundamental error in the decision of the Court of Appeals lies in the court's failure to apply the rule recognized in Thiboutot and Pennhurst. The court erred in finding

a section 1983 remedy to be available even though the respondents' allegations as characterized by the court do not state a violation of section 1396a(a)(13)(A).

Respondents' sole claim acknowledged by the Court of Appeals was the claim that Oregon violated the requirements of section 1396a(a)(13)(A) by establishing a reimbursement rate for respondent Coos Bay Care Center that excluded reimbursement for certain heavy-care costs. However, as has been recognized by the Department of Health and Human Services ("DHHS" or "the Agency"), the federal agency responsible for implementing the Medicaid statute, section 1396a(a)(13)(A) does not require a state to ensure that the specific rate established by the state for each particular provider satisfies the reimbursement standard set forth in the section.

Rather, section 1396a(a)(13)(A) requires only that a state provide for payment to institutional providers at rates about which the state has made findings, and that the state assure the Agency that it has made the requisite findings.

In the preamble to its final regulations implementing section 1396a(a)(13)(A), the Agency described in great detail its understanding of what the section requires. See 48 Fed. Reg. 56046-56059 (1983). The Agency explained that its approval of a State's reimbursement plan, which "indicates that the State has complied with the requirements in [section 1396a(a)(13)(A)] and regulations," is based on the Agency's evaluation of the state's assurances "to determine whether the state has made a finding to substantiate that the payment rates are reasonable and adequate. . .." Id. at 56052. Significantly, the Agency

preamble indicates that, in order to assure the Agency that it has made the requisite findings, a state need not justify nor make any representations about the rates paid to individual providers. Id. at 56050.

The Agency explicitly rejected suggestions, submitted during the comment period, that the Agency's implementing regulations require the states to identify "providers not receiving full costs, and [to provide] an explanation of why providers not receiving full costs are not considered efficiently and economically operated." Id. Instead, "[i]n response to the concern regarding a State explanation as to why a provider is not considered an efficiently and economically operated facility," the Agency determined to require each state to "provide an appeal procedure to address the expressed

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concern of those individual facilities who believe they are efficient and economical but are being adversely affected by the State's payment rates." Id.

In sum, the Agency charged with implementing the Medicaid statute has interpreted section 1396a(a)(13)(A) not to require that a state make assurances about the rates it pays to particular institutional providers. That interpretation is consistent with the congressional intent that section 1396a(a)(13)(A) make participation in the Medicaid program less administratively burdensome for the states, and afford them greater flexibility in designing reimbursement methodologies than they had enjoyed previously. See H.R. Rep. No. 158, 97th Cong., 1st Sess. 293

(1981).[9] The Agency's interpretation that section 1396a(a)(13)(A) does not impose requirements with respect to individual provider rates is a reasonable one,[10] to which this Court should defer.

9/ The Agency's understanding that section 1396a(a)(13)(A) was intended to result in the Medicaid program being less administratively burdensome for the states was also the basis of the Agency's determination not to require that the Medicare upper limit rule (i.e., the requirement that payment rates for institutional providers not exceed the rates that would have been payable under the Medicare program) be applied on a facility-specific basis. 48 Fed. Reg. 56055. The Agency's "regulations allow a State to use an aggregate vs. facility-specific application of the limit . . . in keeping with the congressional intent that the calculation of the limit not be an administrative burden on States." Id. at 56054.

10/ Indeed, it would hardly have been reasonable for the Agency to interpret section 1396a(a)(13)(A) to require states to make guarantees about the sufficiency of individual provider rates.

(Footnote Continued)

Chevron, U.S.A., Inc. v. Natural Resources Defense Council, 467 U.S. 837, 844 (1984); Red Lion Broadcasting Co. v. Federal Communications Commission, 395 U.S. 367, 381 (1969) (great deference should be accorded the construction of a statute by the agency required to execute it).

Amici are aware of only one federal court decision that has addressed the issue of whether the adequacy of the particular rate paid to an individual provider implicates a state's compliance with the requirements of section 1396a(a)(13)(A).11/ In that decision,

(Footnote Continued)
The states lack detailed knowledge about individual providers' financial and operational aspects, and are unable to predict future circumstances that may affect individual provider costs.

11/ Amici note that the recent decision in Bethany Medical Center v. Harder,
(Footnote Continued)

the court expressly held that the requirements of the section may be fully satisfied even though the general rates that a

(Footnote Continued)
No. 85-2415, slip op. (D. Kan. March 12, 1987) permitted a provider to sue under section 1983 for a state's alleged violation of section 1396a(a)(13)(A) in failing to take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs. The court's holding that the plaintiff had stated a claim for a violation of section 1396a(a)(13)(A) was based on plaintiff's amendment of its complaint to allege that the state's assurances that no hospital in the state was a disproportionate share provider had not been based on factual analysis or objective evidence. The case did not hold that the provider was entitled to sue under section 1983 on a mere claim that its individual rate was inadequate in not recognizing its particular costs.

A number of federal courts have entertained suits by providers or provider groups (more commonly the latter) complaining that states had adopted reimbursement methodologies without objective evidence or factual analysis that could support the findings and assurances and the Agency approval required under federal law (a claim that respondents here do not make). The Ninth Circuit Court of Appeals failed to recognize that it was such a complaint,
(Footnote Continued)

a state has established may be inadequate in the case of a particular provider. See, Mary Washington Hospital v. Fisher, 635 F. Supp. 891 (E.D. Va. 1985). In

(Footnote Continued)
(i.e., a complaint about a state reimbursement plan) that was involved in every case cited by the court in support of its decision permitting a suit under section 1983 to challenge a particular provider rate. See 803 F.2d at 1063. (Moreover, none of the cases cited by the court involved section 1396a(a)(13)(A)). The court cited no case in which a federal court has permitted a suit by an institutional provider challenging the adequacy of its particular reimbursement rate.

By contrast, a number of federal courts (reasoning that providers are not the intended beneficiaries of the Medicaid statute) have held that Medicaid providers have no property interest in Medicaid reimbursement entitling them to challenge their individual reimbursement rates in federal court. See, e.g., Oberlander v. Perales, 740 F.2d 116 (2d Cir. 1984); Al-Charles Inc. v. Heintz, 620 F. Supp. 327 (D. Conn. 1985).

Mary Washington, the court, after describing in detail the process by which Virginia had made findings to support its rate-setting methodology,[12] rejected

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12/ The Mary Washington court's analysis implicitly recognized that the obligation imposed by section 1396a(a)(13)(A) is that each participating state make payment to providers through the use of rates about which the state has made findings and can make satisfactory assurances. The court's implicit holding was that section 1396a(a)(13)(A) is violated only when a state has adopted a rate-setting mechanism without having made reasoned findings or has failed to provide the required assurances.

As this Court reasoned in the context of considering a statutory provision imposing analogous "assurance" requirements, "[i]t is at least an open question whether an individual's interest in having a State provide those 'assurances' is a 'right secured' by the laws of the United States within the meaning of § 1983." Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 28 (1980). Careful analysis of section 1396a(a)(13)(A) not only compels the conclusion that the inadequacy of particular provider rates

(Footnote Continued)

a provider's claim that Virginia had violated the requirements of section 1396a(a)(13)(A) in setting reimbursement rates for inpatient hospital services. The court observed:

> "while the court has determined that the general rates Virginia has set for hospital reimbursement are not in conflict with the governing federal law, this conclusion does not mean, however, that those general rates will be adequate in every case. For a variety of reasons, reasonable general rates may not be reasonable and adequate in particular cases to assure reasonable access and to cover the costs of efficiently and economically operating hospitals. This may be due to some fact about a hospital or group of hospitals that the state did not take into account in setting the general rate . . . . Whatever the reason, the appropriate way to deal with this problem . . . is through some form of appeals or

(Footnote Continued)
cannot form the basis of a challenge under section 1983, but also raises the similar issue -- an issue that the Court need not decide here -- of whether a properly alleged violation of section 1396a(a)(13)(A) could ever give rise to a remedy under section 1983.

> exception process." (Emphasis in the original.)

Id. at 903. The Mary Washington court's analysis recognized that the requirements of section 1396a(a)(13)(A) cannot be said to be violated simply because a particular provider's rate is inadequate.

By contrast, the Ninth Circuit Court of Appeals failed even to address the issue of whether a claim that a particular provider rate fails to satisfy the reimbursement standard set forth in section 1396a(a)(13)(A) states a violation of the requirements of the section.13/ The

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13/ The Court of Appeals did reason that it is "actions which properly allege violations of 42 U.S.C. § 1396a(a)(13)(A)" that are entitled to consideration on the merits under section 1983, 803 F.2d at 1061, but failed to address the issue of whether respondents had alleged any conduct or omission that could be deemed a violation of section 1396a(a)(13)(A).



effect of the court's decision, however, is t. permit any provider making such a claim to sue under section 1983. This Court should reverse the Court of Appeals' decision, on the grounds that an allegation that an individual provider's rate is inadequate does not state a violation of section 1396a(a)(13)(A) and, for that reason,[14/] does not give rise to a remedy under section 1983.

14/ The Court need not even reach the question of whether this case falls under one or both of the exceptions to the availability of a section 1983 remedy established by this Court's decisions in Pennhurst and Middlesex County and summarized in Wright v. City of Roanoke Redevelopment & Housing Authority, 107 S. Ct. 766, 770 (1987) (exception to the application of section 1983 to remedy statutory violations exists where Congress foreclosed such enforcement in the statute and where the statute did not create enforceable rights). The threshold question is not whether section 1396a(a)(13)(A) creates any rights enforceable under

(Footnote Continued)

B. The Holding Below Conflicts with the Statutory Objective of Affording the States Broad Latitude in Developing and Implementing Medicaid Reimbursement Methodologies

An additional reason warranting reversal of the decision below is that its effect is to undermine the states' ability to implement the administrative review procedures they have established,

(Footnote Continued)
section 1983, but whether a claim to a particular level of reimbursement for an individual provider comes within the scope of the right (if any) that Congress intended to confer. Cf. Wright v. City of Roanoke Redevelopment and Housing Authority, 107 S. Ct. at 776 (1983) (O'Connor, J., dissenting) (assuming that federal housing statute conferred on tenants rights to enforce provision requiring reasonable rent, question remained whether tenants' claim to reasonable utilities came within scope of right Congress intended to confer); Bumpers v. Clark, 681 F.2d 679, 684 (9th Cir. 1982) (even if provision of Medicaid statute conferred some substantive rights against the states, it did not create the rights claimed by plaintiffs).

and thus their ability to implement fully their reimbursement methodologies.

The point that amici urge the Court to recognize differs in a perhaps subtle, but significant way from an argument that the holding below permits court action before administrative remedies have been exhausted.15/ The point amici make is more basic: each state's administrative rate review procedure is an essential element of its reimbursement system.16/ Accordingly, a judicial

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15/ Thus, the Court need not consider whether this case presents an exception to the rule, established by the cases discussed in Patsy v. Board of Regents, 457 U.S. 496, 507-512 (1986), that exhaustion of state administrative remedies is not a prerequisite to an action under section 1983.

16/ See 48 Fed. Reg. 56056 (1983). In adopting final rules to implement section 1396a(a)(13)(A), DHHS indicated that it was deleting its regulation

(Footnote Continued)

holding that permits a provider to challenge its reimbursement rate under section 1983 without first having resorted

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(Footnote Continued)
requiring state appeals procedures as a separate requirement and instead was placing that requirement in its regulations establishing the general requirements of state reimbursement plans in order to "consolidat[e] the essential elements of a State's reimbursement system to a single section of the regulations," and to make the appeals process the subject of assurances. Id. at 56047, 56056.

Moreover, the federal agency in practice treats the states' appeals procedures as an essential element of their reimbursement plans. Before approving a state's payment methods and standards, the Agency "evaluates [the state's] assurances to determine . . . that appropriate appeals procedures in compliance with the [Agency] regulations are in effect." Id. at 56052.

In addition, it is noteworthy that the states typically describe their administrative rate review procedures in Attachments 4.19-A and 4.19-D of their State Plans, wherein they are required to specify comprehensively their methods and standards of payment for hospitals and long-term-care facilities.

to state administrative rate review procedures requires a state to defend in federal court the rates it has established before the state has had an opportunity to finish applying its rate-setting process by implementing an essential element of that process.

The foregoing is precisely the result of the Ninth Circuit's holding. As a result, the court's decision undermines the congressional intent behind section 1396a(a)(13)(A), that states be afforded broad freedom to develop and implement their reimbursement methodologies. See H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981); Charleston Memorial Hospital v. Conrad, 693 F.2d 324, 331 (4th Cir. 1982). A judicial holding which so frustrates the statutory intent should not be sustained.

C. The Effect of the Decision Below Will Be to Pre-Empt the Congressionally-Mandated State Rate Review Procedures and to Overburden the Federal Court Dockets

Agency regulations at 42 C.F.R. § 447.253(c) require each state Medicaid agency to provide an appeals or exception procedure that allows individual institutional providers an opportunity to submit additional evidence and receive prompt administrative review of their payment rates.17/ In promulgating section 447.253(c), the Agency declined to provide greater specificity in its appeals regulation, recognizing that the states "are in the best position to determine the administrative process that

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17/ The Court of Appeals erroneously observed that Title XIX merely "permits states to establish administrative review procedures for disputes over Medicaid reimbursements" (emphasis added). 803 F.2d at 1062.

would best meet their needs and be most compatible with their reimbursement system." 48 Fed. Reg. 56052.

The amici states have employed the flexibility afforded them under federal regulations, and have invested considerable time and expense in developing administrative review procedures and guidelines carefully tailored to their reimbursement plans. At substantial cost to the states, state administrative officers have developed considerable expertise in applying complex rate formulae, and considerable expertise about local health care industry conditions, provider inflation experience and other relevant factors within their states. State administrative adjudicatory bodies have developed bodies of administrative law on which providers can rely in making rate appeals and to which the states

can refer in resolving rate disputes. Moreover, virtually all of the amici states afford institutional Medicaid providers the right to appeal administrative rate-review decisions to their state courts.18/

18/ See Ariz. Rev. Stat. Ann. § 36-2932H (1987); Cal. Civ. Proc. Code § 1094.5 (1981); Ga. Code Ann. §49-4-153 (Supp. 1987); Haw. Rev. Stat. § 9114 (1983); Idaho Code § 67-5215 (1980 & Supp. 1987); Ind. Code § 4-21.5-5-1 (1986); Kan. Stat. Ann. § 77-601 (1986); La. Rev. Stat. Ann. § 49:964 (1967); Me. Med. Assist. Man. § 1.18 (1979); Mass. Gen. Laws Ann. chs. 6A, § 36, and 30A, ¶ 14 (1976); Mich. Comp. Laws § 400.111f (Supp. 1987); Minn. Stat. § 14.63 (1986); Mo. Rev. Stat. § 621.145 (1986); Mont. Admin. R. § 46.2.212 (1979); Neb. Rev. Stat. § 84-917 (1983); N.Y. Civ. Prac. Law § 78; N.C. Gen. Stat. §§ 150B-43; N.D. Cent. Code § 28-32-15 (1986); Ohio Rev. Code Ann. § 119.12; Utah Code Ann. § 26-23-2 (Supp. 1987); Vt. Stat. Ann. tit. 3, § 815 (1985); Va. Code § 32.1-325.1 (1986); Wash. Rev. Code § 34.04.130 (1985); § 227.53 Wis. Stat. (1985-86).

The effect of the decision below by the Ninth Circuit Court of Appeals will be to disrupt the states' thoughtfully developed and carefully-tailored review procedures by permitting them to be by-passed by providers who prefer to have their day in federal court, and similarly to disrupt developed bodies of administrative law by laying the ground for disparate state and federal decisions. Moreover, in light of the fact that the states annually review thousands of rate appeals, it can realistically be expected that, if the court's decision stands, thousands of new plaintiffs would flood the federal courts with rate disputes -- disputes which the courts, lacking a grounding in the states' highly technical rate-setting mechanisms, are ill-prepared to resolve. That is a result that offends the goals of judicial economy and efficient

use of federal court resources, and for which their is no justifying policy rationale. Nor is there a need for the Court to stretch to find a section 1983 remedy.19/ The states amply provide rate-review remedies, as befits each state in its role of carrying out what is essentially a state medical assistance program.

Thus, policy considerations, too, warrant a judgment by this Court reversing the Court of Appeals' ill-reasoned decision.

19/ Cf. Block v. Community Nutrition Institute, 348 U.S. 340, 348, 352 (1984) (suit of type that could severely disrupt administrative scheme could be precluded since preclusion would not threaten realization of fundamental objectives of statute).

CONCLUSION

For all the foregoing reasons, as well as for the reasons cited in petitioners' briefs, amici urge the Court to reverse the decision below.

Respectfully submitted,

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No. 86-1419

IN THE
SUPREME COURT OF THE UNITED STATES

October Term 1987

STATE OF OREGON
DEPARTMENT OF HUMAN RESOURCES;
RICHARD C. LADD,

Petitioners,

v.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

AFFIDAVIT OF SERVICE

At the request of the First Deputy Attorney General of Hawaii, the counsel of record, I have served the "Brief of the States of Arizona (through the Arizona Health Care Cost Containment System), Arkansas, California, Colorado, Connecticut, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming, and the Northern Mariana Islands as Amici Curiae in Support

of Petitioners" this 25th day of July, 1987, by causing copies thereof to be mailed first-class, postage prepaid to counsel for respondents Donald W. Lojek, Esq. and Bradley H. Hall, Esq., 711-1/2 West Bannock, Boise, Idaho 83701, and Robert J. Saalfeld, Esq., P.O. Box 470, Salem, Oregon 97308. I have also caused copies to be mailed postage prepaid, to Philip Schradle, Assistant Attorney General, Department of Justice, Appellate Division, Justice Building, Salem, Oregon 97310.

On the basis of the foregoing, I hereby certify that all parties required to be served by Rule 28 of the Rules of this Court have been served.

Phyllis D. Thompson

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Subscribed and sworn before me this 25th day of July, 1987.

Notary Public

My Commission Expires: My Commission Expires November 14, 1990.